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EDITORIAL

TREATMENT OF VENEREAL DISEASES IN MERCHANT SEAMEN

The difficulties experienced in the efficient application of the existing antivenereal measures to merchant seamen has long been a matter of concern to venereologists in our large seaports. The recognition some years ago by many of the more enlightened countries of the inadequate facilities for the treatment of their own and foreign seamen eventually led to the International Agreement of 1924, now commonly known as the Brussels Agreement. Under this agreement the participating countries undertook to provide facilities at each of their chief sea and river ports for the gratuitous treatment of merchant seamen without distinction of nationality. The Agreement also required that each patient should be supplied with a brief personal record of the diagnosis and treatment.

This system has worked reasonably well in the past, but a survey of the patients' travelling record cards, more especially in cases of syphilis, has shown that in practice there was room for improvement. It is obvious that the nature of the seamen's calling militates against a perfect regularity of clinic attendances. This is shown very clearly in the records of those men who have spent long periods afloat without the opportunity for getting ashore. Irregularity in treatment is sometimes ascribed by the patients to difficulties in ascertaining the days and hours of the services provided or to a failure to get ashore during these times. Equally pertinent, however, has been the considerable diversity of the treatment given to seamen by the medical officers of port clinics especially in regard to syphilis.

This lack of uniformity in treatment for syphilis was well appreciated by the permanent committee of the Office International d'Hygiene Publique, the body to which any difficulties in the practical application of the Agreement are referred. In their " third communication " of January, 1936, this committee aimed at securing more regular and especially more uniform treatment for seamen in the earlier stages of syphilis and recommended adherence to the schedules of antisyphilitic treatment laid down by the Committee of Experts on Syphilis of the Health Organization of the League of Nations in their Report published in March, 1935.

Some rectification of the previous deficiencies was effected thereby but additional experience since that time, and more especially during the present war when trans-ocean voyages are the rule rather than the exception, has given rise to a desire for further improvement in the welfare of infected seamen. This has culminated in the recent issue by the Ministry of Health of recommendations designed to produce greater uniformity of treatment and to effect the more prompt eradication of infection in merchant seamen. (See page 77.)

The treatment specified for patients with gonorrhoea in its early stages is the customary one with sulphathiazole or sulphadiazine in dosage of 4 to 5 grammes daily for four to seven days, supplemented by urethral irrigations. When the response to this treatment is prompt and signs of infection are not discovered seven days after the end of treatment, the seaman should be discharged to full duty. It is essential, however, that the patient be re-examined ashore at the end of about three months for both gonorrhoea and syphilis. When the disease is discovered whilst the seaman is at sea in a ship not carrying a surgeon, it is recommended that he should be treated daily with 6 grammes of sulphathiazole or sulphadiazine over a period of five days. On arrival at a port he should attend an appropriate clinic for tests.

The known prompt response to this treatment of the overwhelming majority of patients infected with gonorrhoea will doubtless outweigh the disadvantage of the omission of the microscopical confirmation of the apparent diagnosis before treatment is begun.

The long drawn out series of injections in multiple courses in the customary schedules of antisyphilitic therapy have made both doctor and seaman impatient for many years. The civilian is more readily content with treatment of long duration, for almost invariably he is able to remain at work and to obtain the necessary treatment after working hours. The infected seaman, however, is under a great disadvantage. Facilities for treatment are available without cost as for civilians but perfectly regular treatment for the deep-sea sailor is often obtained only by his remaining ashore with a possibility of being unemployed and wageless.

The principle of speedier treatment for ocean going seamen has long been recognized. The Royal Navy medical authorities utilized a compressed course of bi-weekly injections of neoarsphenamine during and since the war of 1914-18. Ross (1930, *Lancet*, **2**, 1206), dealing with merchant seamen at Liverpool, employed a similar compression of treatment the early results of which were reported as excellent. In adopting the principle of acceleration of treatment the Ministry of Health recommends a scheme of condensed courses of injections. The scheme permits some slight variation for the different types of employment at sea. Men who are ashore and who will return to deep-sea service in ships not carrying a surgeon are given a speedier treatment than seamen on coastal service who can attend a port clinic once a week. The scheme, with its total dosage of 5·4 grammes in thirty-nine days approximates in dosage to certain of the "abortive treatment" courses which were popular in Europe some years ago.

The present standard treatment of syphilis has been gradually elaborated by the patient evaluation of the end results of therapy, especially by the inquiries and recommendations of the League of Nations Health Organization and of the Co-operative Clinical Study Group in the United States of America. This standard treatment necessitates in the concurrent intermittent schemes for early syphilis three, four or five unit courses, each of ten to twelve weekly injections of neoarsphenamine and bismuth, separated by intervals of two to four weeks. If the patient is able to attend regularly for treatment, this long-continued saturation is the method of choice and yields a cure rate approximating 100 per cent. Many clinicians consider, and, based on the examination of returned defaulters, there is some support for this belief, that early syphilis is often cured by the first unit course of treatment. But it is certain that clinical or serological relapse may occur if anything less than the full course of treatment is given.

The present recommendations must therefore be accepted as a compromise expedient designed to secure for seamen a reasonable prospect of rapid cure without undue immobilization of much needed manpower. Adequate surveillance is necessary to evaluate the ultimate clinical and serological results. In practice the course has not so far been followed by any noticeable increase of intolerance.

The immediate treatment in civil clinics of gonorrhoea on clinical grounds alone but without pathological confirmation of the diagnosis would be reprehensible. On the other hand the earlier the use of the newer sulphonamides in such cases the more certain and speedy is the prospect of cure. Academic accuracy must give place to more urgent considerations. The danger is of inculcating a casual attitude to diagnosis, to tests of cure and to serological exclusion of possible concomitant syphilitic infection.

The expedient of today may become the accepted practice of tomorrow, and it would be regrettable if the present recommendations should lead to any general lowering of currently accepted standards. The rapid increase of the venereal diseases renders the maintenance of the most rigid standard of diagnosis, treatment and tests of cure imperative not only for seamen and other itinerant classes, but also for the fixed population. The recommendations in the Ministry of Health Memorandum could with advantage be applied as a standard procedure for routine civilian use.

We believe that the majority of venereologists not only would welcome authoritative guidance, but would eagerly participate also in the mass evaluation of the end results of treatment.